STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012113	A. BUILDING: _____ B. WING _____	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY MEDICAL AND SURGICAL HOSPITAL	4455 EDISON LAKES PKWY MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 00012113 Type of Survey: State Licensure Off Site AOA-HFAP Accreditation Survey Date of AOA-HFAP On Site Survey - Hospital full survey October 1-3, 2012 Date of ISDH off site review - 9/16/2013 Reviewer/Surveyor -Nancy Otten, RN, PHNS Based on review of the 10/1-3/2012 AOA-HFAP Accreditation Survey Report, it has been determined that Unity Medical and Surgical hospital meets the requirements for Hospital Licensure in Indiana for 2012.	S 000		